LENOIR
UNC HEALTH CARE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
HEALTH INFORMATION SERVICES DEPARTMENT

NOTICE: There will be a charge for a personal copy of your records. An outside Release of Information company has been contracted to provide this service and will invoice you directly. We will be happy to fax a copy of your record to another healthcare provider at no charge.

I authorize UNC Lenoir Health Care to use or disclose to:

Name of Person or Facility			
Address	City	State	Zip
Phone	Fax	Email	

The protected health information of:

Patient Name	Date of Birth	SS# (last 4):
Address	City	State	Zip
Phone:	UNC Medical Record #	

Dates of Service: _____

Put a <u>CHECKMARK</u> next to the specific documents that apply to your request

	Emergency Dept. notes		Operative/Procedure notes		Progress Notes
	History and Physical		Physician Orders		Radiology Reports
	Discharge Summary		Nursing Notes		Consultations
	CD (Imaging Support)		Laboratory Reports		All Medical Records
	Abstract (All Physician dictated reports & test results)				
	Other (describe)				

Put a <u>CHECKMARK</u> next to the purpose of the request:

	Attorney/Legal		Continued Patient Care		Insurance
	Personal Use		Social Services/Disability Determination		Workers Comp

Put a <u>CHECKMARK</u> next to how you would like to receive your request:

	Mail to address listed above		Fax to # listed above (Health Care providers only; no personal faxes)		Pick up in Release Dept. (HIS)
	Review in person (HIS dept.)		Other (Specify)		

I UNDERSTAND THAT:

- I may revoke this Authorization at any time:
  - The revocation will not apply to information that has already been released in response to this Authorization.
  - I must revoke this Authorization in writing. The procedure for revoking this Authorization is to present my written revocation to the Health Information Management Department.
- I may refuse to sign this Authorization:
  - My treatment, payment, enrollment in a health plan, or eligibility for benefits cannot be conditioned upon my authorization of this disclosure.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.

- I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 C.F.R. Part 2), HIV/AIDS and other communicable diseases, and genetic testing. This authorization does not include permission to release psychotherapy notes (defined as records from private, joint, group, or family counseling sessions that are separated from the rest of the patient's medical record). Release of psychotherapy notes requires a separate authorization
- Unless revoked earlier, this authorization will remain in force for ninety (90) days from the date of signature on this form. Upon the conclusion of that time period, this authorization is automatically revoked and no further use of the patient's confidential healthcare information is permitted without completion of the new authorization.

I have read and understand the information in the Authorization form.

Signature of Patient:		
Printed Name:	Date	Time:
Or		
Signature of Authorized Representative		
Printed Name:	Date:	Time:
Please explain Representative's authority to act on behalf of the Patient:		

****** Authorizations not signed in the presence of a UNC Lenoir Health Care employee must be notarized. ******

Signature of Notary:_____My Commission Expires:_____

Sworn to and Subscribed before me on this, the_____day of _____20 _____

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OFFICE USE ONLY

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